Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RENAISSANCE HOSPITAL DALLAS
C/O BURTON & HYDE PLLC
311 WEST 15TH STREET STE 100
AUSTIN TX 78701

Carrier's Austin Representative Box
#19

MFDR Date Received
OCTOBER 3, 2006

Respondent Name
AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number
M4-07-0732-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Taken From The *Table of Disputed Services*: "Carrier did not reimburse at Stop Loss. Hospital is requesting to be reimbursed at Stop Loss. Carrier denied request for reconsideration."

Requestor's Supplemental Position Summary Dated February 22, 2013: "1. **The Audited charges of $92,693.32 for [Claimant's] hospital inpatient admission exceeds the $40,000 stop-loss threshold**. …2. **The services rendered to [Claimant] were unusually costly and extensive** …:

- **[Claimant] underwent multiple surgeries.** [Claimant's] hospital stay involved multiple surgical procedures, which included: (1) two-level anterior cervical discectomy at C4-5 and C5-6; (2) partial corpectomy with removal of the posterior-inferior portion of the body of C4; (3) partial corpecromy with removal of the posterior-superior body of C5; (4) partial corpectomy with removal of the posterior-inferior portion of the body of C5; (5) partial corpectomy with removal of the posterior-superior body of C6; (6) interbody fusion at C4-5 and C5-6 with Blackstone structural allograft; (7) supplementation of the structural allograft with morselized allograft; (8) use of the Biomet stem cell harvest to mix with the allograft; and (9) rigid fixation with an anterior plate and screws using the Scientix system.
- **The cost of the admission was outside of the ordinary.** [Claimant's] hospital admission was outside of the ordinary because the cost of the services for this admission when compared to the results of a statistical survey of system-wide data maintained by the Division for hospital inpatient admissions in Texas exceeded the norm. The average amount billed for hospital inpatient admissions system-wide in the State of Texas in 2005 was $29,863.42. The average amount billed for hospital inpatient admissions with Principal Diagnosis Code (722.0) and Principal Procedure Code (81.02) in 2005 was $36,262.02. The charge for [Claimant's] admission was $92,693.32. [Claimant's] hospital admission was outside of the ordinary because the amount billed was greater than the system-wide average for 2005. Her admission is particularly unusual though because it greatly exceeded the average cost for admissions involving the same Principal Code and Principal Diagnosis.
- **The length of stay was outside of the ordinary.** When compared to the results of a statistical survey of system-wide data maintained by the Division for Hospital inpatient admissions in Texas, [Claimant's] two (2) day hospital stay was outside of the ordinary because it was longer than most others and exceeded system norms. The average length of stay for 2005 admissions with Principal Diagnosis Code (722.0) and Principal Procedure Code (81.02) was one (1) day. [Claimant's] hospital stay was outside of the ordinary (unusual) because the length of stay, two (2) days, exceeded the average length of stay for inpatient admissions

system-wide in the state of Texas involving the same Principal Procedure Code and Principal Diagnosis Code.

- **[Claimant's] surgeries were complicated by her medical conditions.** The preoperative laboratory report for [Claimant] showed a higher than normal level of eosinophilia which can be an indication of infection, parasites, cancer, or medical conditions. Also, [Claimant's] cholesterol was in the high risk level indicating that blood flow could be decreased and artery blockage could be present putting her at greater risk of heart attack or stroke during her surgeries. These conditions had to be monitored and managed by the hospital's staff.
- **[Claimant] experienced postoperative complications.** [Claimant] spiked a low fever a day following her surgeries. This complication was attended to and managed by the hospitals staff.
- **The costs were front-loaded.** The cost associated with the hospital's services in this case are front loaded. [Claimant's] underwent a complicated surgical procedure requiring an investment in skilled professionals and advanced facilities and medical equipment. There were numerous skilled medical professionals present for [Claimant's] surgical procedures, which included a surgeon (Dr. Vaughan), an assistant (Dr. Buhkan), an anesthesiologist (Dr. Lee), neuro-monitoring doctor (Dr. Nosnik), two scrub nurses (Ms. McMichael and Ms. Huffman), and a circulating curse [sic] (Ms. Bryant). Additionally, [Claimant] had numerous skilled medical professionals for her post-operative care (i.e. nurses, radiologist, physical therapist, and etc.)…For these reasons, the Medical Fee Dispute Officer should find that the second-prong of the two part test is satisfied and order additional reimbursement be paid by the carrier according to the stop-loss calculation methodology."

Amount in Dispute per Amended Table submitted on July 31, 2007: $59,248.49

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated October 25, 2006: "Requestor billed a total of $92,693.32. The Requestor asserts it is entitled to reimbursement in the amount of $69,519.99, which is 75% of the total charges. Requestor has not shown entitlement to this alternative, exceptional method of calculating reimbursement and has not otherwise properly calculated the audited charges."

Respondent's Position Summary Dated August 30, 2011: "Subject to Respondent's objection to even consideration of Requestor's belated switch to an entirely new claim, from an evidentiary and statutory compliance standpoint, the TWCC, the Commissioner, MRD and SOAH have routinely rejected this simplistic, unsophisticated and unscientific methodology most recently proffered by Respondent, Requestor does not even attempt to provide any rationale, much less a compelling one, for reversing years of well reasoned precedent. No evidence of compliance with the eight requirements for 'fair and reasonable' is provided by Requestor. Requestor has provided non rationale to support a claim for additional reimbursement."

Respondent's Position Summary Dated September 8, 2011 and February 13, 2013 : "Respondent submits this Respondent's Post-Appeal Supplemental Response as a response to and incorporation of the Third Court of Appeals Mandate in Cause No. 03-07-00682-CV…Based upon Respondent's initial and all supplemental responses, and in accordance with the Division's obligation to adjudicate the payment, in accordance with the Labor Code and Division rules, Requestor has failed to sustain its burden of proving entitlement to the stop-loss exception. The Division must conclude that payment should be awarded in accordance with the general *per diem* payment in accordance with 28 Texas Administrative Code §134.401 (repealed)…"

Responses Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
December 21, 2005 through December 23, 2005	Inpatient Hospital Services	$59,248.49	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of Benefits

   - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE.
   - 42 – CHARGES EXCEED OUR FEE SCHEDULE OR MAXIMUM ALLOWABLE AMOUNT.
   - 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE.
   - 226 – INCULDED IN GLOBAL CHARGE.
   - 253 – IN ORDER TO REVIEW THIS CHARGE WE WILL NEED A COPY OF THE INVOICE.
   - 790 – THIS CHARGE WAS REDUCED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
   - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED.

5. U.S. Bankruptcy Judge Michael Lynn issued a "STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS," dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.*, in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the claim adjudication process as to the workers' compensation receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 trustee of the debtor's estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer's behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.

Issues

1. Did the audited charges exceed $40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission,

position or response as applicable. The division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $92,693.32. The Division concludes that the total audited charges exceed $40,000.
2. In its original position statement, the requestor asserts that "Carrier did not reimburse at Stop Loss. Hospital is requesting to be reimbursed at Stop Loss." 28 Texas Administrative Code §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The Third Court of Appeals' November 13, 2008 opinion states that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." The requestor's original position statement failed to discuss the particulars of the admission in dispute that may constitute unusually extensive services. In its supplemental position statement, the requestor considered the Courts' final judgment. In regards to whether the services were unusually extensive, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually extensive services. The requestor's supplemental position statement asserts, that "The services rendered to [Claimant] were unusually costly and extensive…because: [Claimant] underwent multiple surgeries. [Claimant's] surgeries were complicated by her medical condition. [Claimant] experienced postoperative complications." The requestor's position that this admission is unusually extensive due to surgical procedures and complications fails to meet the requirements of §134.401(c)(2)(C) because the requestor failed to demonstrate how the services in dispute were unusually extensive in relation to similar surgeries or admissions.

   The requestor goes on to state:

   > The length of stay was outside of the ordinary… When compared to the results of a statistical survey of system-wide data maintained by the Division for Hospital inpatient admissions in Texas, [Claimant's] two (2) day hospital stay was outside of the ordinary because it was longer than most others and exceeded system norms. The average length of stay for 2005 admissions with Principal Diagnosis Code (722.0) and Principal Procedure Code (81.02) was one (1) day. [Claimant's] hospital stay was outside of the ordinary (unusual) because the length of stay, two (2) days, exceeded the average length of stay for inpatient admissions system-wide in the state of Texas involving the same Principal Procedure Code and Principal Diagnosis Code.

   The Third Court of Appeals' November 13, 2008 opinion states that "…independent reimbursement under the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." A review of the data reports provided by the requestor finds that although length of stay for the services in dispute exceeded the average length of stay when compared to admissions with the same principal diagnosis and procedure code, the requestor did not demonstrate or explain how merely exceeding the average length of stay would: (1) constitute unusually extensive services; (2) categorize this case among the relatively few cases to which the stop-loss method may apply. The division concludes that the requestor failed to meet the requirements of 28 Texas Administrative Code §134.401(c)(2)(C).
3. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor in its supplemental position summary states:

[Claimant's] hospital admission was outside of the ordinary because the cost of the services for this admission when compared to the results of a statistical survey of system-wide data maintained by the Division for hospital inpatient admissions in Texas exceeded the norm. The average amount billed for hospital inpatient admissions system-wide in the State of Texas in 2005 was $29,863.42. The average amount billed for hospital inpatient admissions with Principal Diagnosis Code (722.0) and Principal Procedure Code (81.02) in 2005 was $36,262.02. The charge for [Claimant's] admission was $92,693.32. [Claimant's] hospital admission was outside of the ordinary because the amount billed was greater than the system-wide average for 2005. Her admission is particularly unusual though because it greatly exceeded the average cost for admissions involving the same Principal Code and Principal Diagnosis.

The division notes that the audited charges of $92,693.32 are discussed above as a separate and distinct factor pursuant to 28 Texas Administrative Code §134.401(c)(6)(A)(i)). The requestor asserts that because the amount ***billed charges*** exceeds the average for the same principal diagnosis and procedure codes, the ***cost*** of the services is therefore "out of the ordinary." Although the requestor lists and quantifies ***billing*** data, the requestor fails to list or quantify the ***costs*** associated with the disputed services. In the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276, the division concluded that "hospital charges are not a valid indicator of a hospital's costs of providing services."

The requestor further states:

The costs were front-loaded**.** The cost associated with the hospital's services in this case are front loaded-i.e. the injured employee underwent complicated surgical procedures requiring an investment in skilled professionals and advanced facilities and medical equipment.

The requestor does not list or quantify the costs associated with these resources in relation to the disputed services, nor does the requestor provide documentation to support a reasonable comparison between the resources required for the spinal surgery. Therefore, the requestor fails to demonstrate that the resources used in this particular admission are unusually costly when compared to resources used in other types of surgeries.

The division concludes that the billed charges for the services do not represent the cost of providing those services. The requestor fails to demonstrate that the hospital's resources used in this particular admission are unusually costly.

4. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

- Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was two days. The surgical per diem rate of $1,118.00 multiplied by the length of stay of two days results in an allowable amount of $2,236.00.
- 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)."
- A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at $43,802.70.
- The Division finds the total allowable for the implants billed under revenue code 278 is:

Description of Implant per Itemized Statement	QTY.	Cost Per Unit	Cost + 10%
Cervical Screw 4.0x14mm Scientx	4	$225.00	$990.00
DBS Boost 10cc Putty	1	No support for cost/invoice	$0.00
26MM Plate	1	No support for cost/invoice	$0.00
Holding Pins	2	$95.00	$209.00
Cortical Cancellous Cervical Allograft	2	$1,495.00	$3,289.00

Cervical Screw 4.0x12mm Scientx	1	$225.00	$247.50
IMP Staple PSW-35	1	No support for cost/invoice	$0.00
14MM Primary Screw Blackstone	6	No support for cost/invoice	$0.00
Cervical Plate 46MM Scientx	1	$1,500.00	$1,650.00
Dynamic Locking Plate	3	No support for cost/invoice	$0.00
Suture Class III	1	No support for cost/invoice	$0.00
TOTAL	23		$6,385.50

The division concludes that the total allowable for this admission is $8,621.50. The respondent paid $10,271.50. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	05/22/2013 Date
Signature	Medical Fee Dispute Resolution Manager	05/22/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.